

**HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EMPLOYMENT RECORDS
PURSUANT TO 45 CFR 164.508**

Name or specific identification of the person(s), or class of persons, authorized to make the requested disclosure:

Employee

Name: _____ A/K/A: _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize disclosure of all protected medical or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to present, including the following:

- All employment information, records and reports, including all tax records, employee reviews, and payroll information.
- All medical information, records and reports, including disability employment applications and disability records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)

Yes, disclose HIV/AIDS information No, do NOT disclose HIV/AIDS information
 Yes, disclose alcohol/substance abuse information No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to:

Defendant(s) Counsel

Gibbons, P.C.
One Gateway Center
Newark, NJ 07102-5310

and/or

Medical Research Consultants (MRC)

and/or

The Marker Group

I acknowledge the right to revoke this authorization by writing to Gibbons, P.C. at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.

I acknowledge the right to inspect the material to be released.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires _____ years/months from the date below.

Signature: _____ Date: _____

Relationship to the person who is the subject of the records:

Self: _____

Other: _____
Describe authority